

Journal: Pain Management

Article type: Editorial/Review

Title: Should health promotion be on the pain agenda?

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## <H1> Introduction

Reference to pain is absent from definitions of health, although freedom from pain is an important dimension of health as reflected in the promotion of pain relief as a fundamental human right by the International Association of Pain (IASP) with the World Health Organization (WHO) [1, 2]. Despite being a major health care problem, pain is missing from health promotion discourse [3]. There is an absence of health promotion in textbooks dedicated to psychosocial aspects of pain (e.g. [4]) and limited research on health promotion and pain. A PubMed search (15 April 2014) of “Health Promotion” [MeSH] obtained 52,540 hits and “Pain” [MeSH] obtained 299,811 hits but there were only 198 hits when the terms were combined, with only 9 hits having “Health Promotion” and “Pain” in the title [5-14]. None focused on health promotion and chronic pain in its broadest sense. The purpose of this article is to speculate on the lack of health promotion in the pain discourse and to explore the potential for health promotion strategies and interventions in the prevention and management of chronic pain.

## <H1> Health Education

The terms “health education” and “health promotion” are often used interchangeably but those specializing in health promotion see a definite difference between the two. Health education is prominent in pain management because it is understandable in a ‘commonsense’ way. Most people have received some form of health education at school and through messages provided by public service broadcasters, the media and other agencies, such as information on the number of units of alcohol that it is safe to consume. Pain education is about imparting information and advice to practitioners and patients. It is well documented that health care professionals fail to recognize, assess and treat pain appropriately, due in part to minimal education about pain and its management in the medical and allied health curricula [15]. Pain education helps patients to understand pain, to know how to seek appropriate health care and to have information to self-advocate and feel empowered to demand services. Pain education is often delivered as part of a pain management package where patients are encouraged to reflect on their attitudes and beliefs that may be unhelpful, such as catastrophizing and fear avoidance. Pain

management programmes use pain education in a formal context where patients are encouraged to self-reflect, goal set and pace their activities to help manage their pain. Skills associated with coping, self-efficacy and perceived-control are developed so that a greater sense of personal control and self-reliance are achieved. Patients monitor emotional distress and thought processes and use thought-stopping techniques and coping statements to reduce negative appraisals (e.g. via Mindfulness, Cognitive Behavioural Therapy and Acceptance and Commitment Therapy). In addition, patients are educated about the use of self-administered techniques including exercise and stretching, pain modulation, distraction, and sleep hygiene.

Pain education is very much downstream by managing the situation once pain has become a problem. Moreover, knowledge is only one of the factors affecting the choices people make about their health. Other factors, such as low income, may have a greater effect on choice and decision-making but may be outside of the control of individuals and families. So, it is not fair simply to tell people of the 'right' actions to take to produce healthy outcomes but it is also incumbent upon policy makers to provide the means to put those decisions into practice. These critiques led to the paradigm shift to 'health promotion' in the mid-1980s.

## <H1> Health Promotion

Health promotion is a more complex and less easily definable idea than health education [16]. The definition of health promotion in PubMed is "Encouraging consumer behaviors most likely to optimize health potentials (physical and psychosocial) through health information, preventive programs, and access to medical care" (<http://www.ncbi.nlm.nih.gov/mesh/68006293>). This definition would not be seen appropriate by many health promotion specialists because it is limiting and limited. Moreover, the epistemic health promotion community itself has internal differences about what health promotion is. These differences can best be encapsulated into a difference between the medical and social models of health promotion.

The 'medical model' of health promotion describes an approach which tries to prevent clinically defined conditions by persuading individuals to adopt attitudes and behaviours which have health benefits, backed up by 'objective' evidence, such as not smoking, exercising and eating well. The 'social model' of health promotion seeks to change the environment such that the social injustices which create poor health are reduced (e.g. poverty, poor housing and lack of employment). Health promotion is an upstream activity, focusing on prevention and attempting to create the right social conditions that result in health for all. The WHO definition, created by the landmark Ottawa Charter, says, 'Health promotion is the process of enabling people to increase control over, and to improve, their health' [17]:p1).

The Ottawa Charter provides the cornerstone for modern health promotion identifying five areas for action to create healthier societies: healthy public policy; the creation of supportive environments; the strengthening of viable communities; the development of personal skills (including health education); and the reorientation of health services. An example of encouraging greater physical activity which is known to improve outcome in many chronic pain conditions demonstrates how these areas for action can be put into practice. In encouraging greater physical activity, health education is limited to telling people the benefits, and hoping that people will act. If the five areas of the Ottawa Charter are brought into play then much more could be achieved through the development of public policy and supportive environments such as improved public transport, cycle lanes, pedestrian safety, and subsidized swimming and leisure facilities. Viable communities could be strengthened by building skills through strong community associations, sports clubs, trust and safety, and the development of personal skills by understanding the importance of activity, how to develop abilities, and how to access facilities and activities. The reorientation of health services would include better education of health care staff in how to help people to keep mobile and increase their physical activity levels.

Health promotion also has a commitment to tackling health inequalities and health injustice. 'Health as a right' is an important value in health promotion, emphasizing

the need for people being empowered to take control of the determinants of their health. The global burden of pain has resulted in calls for pain to be promoted as a public health issue and requiring attention as a human right [2]. "According to international human rights law, countries have to provide pain treatment medications as part of their core obligations under the right to health; failure to take reasonable steps to ensure that people who suffer pain have access to adequate pain treatment may result in the violation of the obligation to protect against cruel, inhuman and degrading treatment" [18]p1. Moreover, the politicized nature of health promotion is about "representing marginalized populations, advocating equity, giving voice to the powerless and educating people in civic rights, democracy and politics, that is, in citizenship. In this respect, health promotion represents a humanist discourse aimed at creating a more equal and just society" [19]: p608).

Clearly health promotion adopts a broad, social definition of health as outlined in Labonte's model [20]. The aim of health promotion becomes how to achieve wellbeing, at the core of the model, as well as good social relations, ability to do the things one enjoys and control over life that will create wellbeing. These components lie outside of health service provision and this is why emphasis is given to the idea of a 'social' rather than 'medical' model of health. The social model of health is essentially concerned with those factors that produce health (i.e. 'salutogenic') and contrasts with traditional thinking about pain dominated by pathogenic ideology such as hospitals, illness and of the loss of health.

<H1> What can health promotion offer to chronic pain management?

The role of health promotion within chronic pain management is less clear than pain education due in part to health promotion being essentially an upstream activity, working to prevent the development of problems. Pain is usually an indication that something has already 'gone wrong' and is essentially a 'downstream' phenomenon. Advocacy is a central activity for health promoters. Pain practitioners could play a greater role in advocating for those conditions that prevent pain and place awareness of it 'upstream'. It is recognized that to prevent chronic pain, interventions are required that enable people change to healthier lifestyles, to

increase mobility and maintain a healthy weight. However, the wider health community may not perceive chronic pain as a hindrance to, and a result of, limited physical exercise. Pain experts have therefore, an educative role with the public health and health promotion community and can contribute to those measures that would enable a supportive, pain-free environment. This would require more dialogue between the two communities of health promoters and pain experts.

Pain experts could also place an inequalities agenda more firmly to the fore, given that a pain-free life is not distributed fairly [21]. Understanding the determinants of pain-free lives, upstream, could mitigate the development of pain further down the line and thus contribute to tackling health inequalities and increasing health justice [22, 23]. The pain community seems more comfortably located within the medical model of health but awareness of a social model might offer insights as to how people perceive, cope and live with pain. A social model of health promotion can help to explain why people still feel a sense of wellbeing despite the presence of pain.

As this is a discussion paper, we do not necessarily have the answers ourselves, and we have found it challenging and stimulating to consider how our two disciplines could gain from cross-fertilization. Potential areas for the development of a health promotion agenda for pain could include creating and strengthening supportive environments and viable communities for individuals with chronic pain and re-orientating health services, so, for example, pain management services and treatments are more equally distributed among populations. It is hoped that a dialogue of the usefulness of health promotion to pain prevention and management will foster cross-disciplinary fertilization and the identification of innovative research directions.

## <H1> Acknowledgments

- (1) contributions that need acknowledging but do not justify authorship – none
- (2) acknowledgments of technical help – none

(3) acknowledgments of financial and material support, specifying the nature of the support – none

(4) financial arrangements that may represent a possible conflict of interest - none

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